Mental Health in New Hampshire Correctional Facilities

Costs and Quality of Care

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EXECUTIVE SUMMARY

In response to increased awareness, both nationally and in New Hampshire, of the mental health needs of prison inmates this report aims to provide New Hampshire policymakers with a better understanding of the status, challenges, and policy options New Hampshire faces with regard to mental health care.

The information presented here follows two tracks: cost and quality. With regard to cost, this report covers the current costs, potential areas of improvement, and available policy options particularly regarding opportunities for cost reduction.

The current costs of providing mental health care to inmates are high due to recidivism, the loss of Medicaid for inmates while in prison, expensive psychotropic drugs, an expensive contract with Dartmouth Medical School (DMS), and a growing elderly population in prisons.

Policy options to help reduce costs of mental health care for inmates include:

- Create diversion programs
- Continue and broaden use of mental health courts
- Consider using telemedicine
- Consider changing to generic psychotropic medications

With regard to quality, this report addresses the less empirical – though equally and possibly more important – aspect of services to the patient upon entering prison, care and treatment while within the correctional system, and transitional services upon the community.

Policy options to improve the quality of mental health care for inmates include:

- Improve patients' needs assessment
- Make greater use of outside services, specifically DMS
- Focus on and improve corrections officer training
- Create a "fast track" program to facilitate the application/re-application process for Medicaid before an inmate's release date

1. COSTS

1.1 Current status of mental health costs in New Hampshire prisons

New Hampshire has four state prisons and ten county prisons. The state prisons are fully funded by the state, and the county prisons are fully funded by the counties. While the state budget currently has a line item for the Department of Corrections and the Division of Medical and Forensic Services within the Department of Corrections, it does not have a line item for mental health care specifically.

In 2006, the Department of Corrections spent $90,302,000, while the Division of Medical and Forensic Services, responsible for coordinating the physical and mental health of all inmates spent a total of $8,275,000, or 9.2 percent of the total Corrections budget.[1] The largest direct costs of providing mental health care to inmates included contracting costs for psychiatric services, costs of maintaining the Secure Psychiatric Unit (SPU) in the State Prison for Men in Concord, and costs of providing expensive psychotropic medications.

The majority of the Corrections budget is allocated to Dartmouth Medical School (DMS), the Secure Prison Unit, and psychotropic drug prescriptions. These are described in more detail below.

1.1.1 Contracting out to Dartmouth Medical School

The New Hampshire Department of Corrections contracts out its psychiatric services to the Psychiatric Department at Dartmouth Medical School (DMS). Before 2001, the Corrections Department contracted out its psychiatric services to individual psychiatrists. Due to scheduling difficulties with individual physicians, the Corrections Department made the decision to contract out its psychiatric services to the medical school, making it one of the only state correctional departments in the country to contract its services to a medical school department.[2] The state uses the contract to fill treatment staff positions in the Secure Psychiatric Unit in Concord and to employ a medical director of forensic services. The medical director is in charge of all inmate mental health services provided by the department and reports clinically to the Department of Psychiatry at Dartmouth Medical School.[3] Having served the four state prisons since 2001, the contract has since been expanded by the state, which has increased the budget and associated costs of the contract. In 2007, the state expanded women's services, hiring a Chief Psychiatrist, a PhD Therapist, and a Master Therapist specifically for female inmates.[4] The cost of contracting in 2006 amounted to $1,276,662, or 13 percent of the overall Division of Medical and Forensic Services budget.[5]

1.1.2 Secure Psychiatric Unit

The Secure Psychiatric Unit (SPU) houses individuals who are waiting for court-ordered evaluations concerning determinations of insanity or competency to stand trail.[6] With a total of 60 beds, the SPU also traditionally houses mentally ill inmates for whom the

counties are unable to provide services. Due to overcrowding in jails, however, many county jails are currently unable to send their mentally ill prisoners to the SPU. Dartmouth Medical School provides psychiatrists and therapists to help with the treatment of these inmates.

Table 1. Costs of psychiatry contract and Secure Psychiatric Unit (SPU)

	2005	2006	2007
Psychiatry Contract	$1,235,975	$1,276,662	$1,321,537
SPU	$3,264,900	$3,400,098	$3,604,157

Source: New Hampshire Department of Corrections, *Inpatient and Outpatient Psychiatric Services RFP*[7]

1.1.3 Psychotropic Medications

In addition to the above costs, the Division of Medical and Forensic Services spent $1,058,600 of their budget on psychotropic medications for inmates.[8] At any given point in time, 25 to 35 percent of state inmates use psychotropic medications, and the number of these medications dispensed has increased over the past few years (Table 2). This increase may be partially correlated with the growing elderly population in the correctional system and the subsequent increase in demand for psychotropic medications. In addition, the cost of psychotropic medications has increased nationally. The state uses expensive brand name medications, such as the anti-psychotic medication Seroquel, as opposed to less expensive generic medications.

Table 2. Costs of psychotropic medications and numbers dispensed 2004-2006

Fiscal Year	Cost of Psychiatric Medications Dispensed	Number of Psychiatric Medications Dispensed
2006	$1,058,600	19,030
2005	$861,700	18,105
2004	$698,300	16,399

Source: New Hampshire Department of Corrections, *Inpatient and Outpatient Psychiatric Services RFP*[9]

1.2 Cost-related policy recommendations

Given the increasing mental health needs of the prison population, New Hampshire may wish to explore opportunities for cost reduction. This section provides an overview of some policy options that achieve the goal of cost reduction without compromising quality.

1.2.1 Diversion Programs

In 2007, New Hampshire's prison population growth far exceeded that of any other state in the Northeast, with a growth rate of 6.6 percent.[10] Representing an increase of 186 prisoners in the New Hampshire corrections system in 2007 alone, such high growth has tremendous cost implications for state and county corrections budgets. This growth

reflects a nationwide increase in the number of people in prison that has continued for three decades.[11]

As growing numbers of incarcerated people continue to plague state corrections budgets, policymakers have begun to consider ways to slow these increases. One of the most logical means of decreasing the prison population is to simply divert potential prisoners from entering the corrections system.[12] Mentally ill individuals, who represent an increasingly large component of the growing prison population, have been targeted by many diversion programs aiming to reduce the number of people who enter the criminal justice system by providing better assessment, treatment, and community services for the mentally ill. Many successful diversion programs involve collaborative partnerships between local police, mental health agencies, and the state.[13] The following are several examples of successful diversions programs instituted in other states:

- *Memphis, Tennessee: Memphis Crisis Intervention Team.* Supported by mental health providers and the local chapter of the National Alliance for the Mentally Ill, the Memphis Police Department uses specifically trained police officers to intervene in crisis situations involving mentally ill individuals. While nearly half of the "crisis calls" are settled on the scene, the other half are provided opportunities to engage in local, community-based treatment programs offered by the city. Furthermore, transfer of patients from police custody to mental health facilities is eased by cooperation between the two. Finally, Memphis offers programs for pre-trial diversion as well. By incorporating mental health providers in the training process, this program provides an integrated approach to the diversion of mentally ill individuals from entering the criminal justice system and has proven effective in providing treatment options for such individuals within the community.[14]
- *San Diego County and City, California: Mental Evaluation and Psychiatric Emergency Response Teams.* The San Diego County Sheriff's Mental Evaluation Team (MET) pairs mental health professionals with uniformed police officers to respond quickly to individuals involved in a psychiatric crisis situation. The MET then arranges admissions if necessary. In operation since 1993, the MET has "saved an average of $2,200 per case in reduced jail costs and officer time."[15] Furthermore, with a goal of eliminating unnecessary incarcerations, the San Diego Police Department's Psychiatric Emergency Response Team (PERT) has expanded the local diversion efforts. PERT successfully diverted 99% of the 3,000 cases it received in the first two years of operation to county mental health facilities instead of jail.[16]
- *Seattle, Washington: Crisis Intervention Team.* The Seattle Police Department's Crisis Intervention Team (CIT) provides participating officers with 40 hours of training in the recognition of and proper intervention in mental health crisis situations. The Seattle CIT then arranges for the transport of mentally ill or addicted individuals to a 24-hour triage center for screening, treatment and referral to follow-up treatment.[17]

- *Albuquerque, New Mexico: Diversion Program*. Under court order to reduce its population in order to improve services to the mentally ill, the County's Detention Center worked with the New Mexico Alliance for the Mentally Ill to foster communication and collaboration between the criminal justice and mental health systems. With state Department of Health funding to establish a jail diversion program for the mentally ill, the pre-trial services program works with law enforcement and mental health professionals to promote treatment over jail time. The program provides diversion services both before and after booking. Within the police department, a mental health Crisis Intervention Team is trained to intervene and transport individuals to local mental health agencies for evaluation or treatment. Post-booking diversion consists of pretrial screening for conditional release. While within this system, mental health professionals develop treatment plans and a recommendation for the judge regarding each individual. This program saves the county an estimated $400,000 per year.[18]

1.2.2 Mental Health Courts

A more recent phenomenon, mental health courts serve as a link between the mental health treatment system and the criminal justice system, providing diversion from traditional incarceration for mentally ill individuals. Since their inception in late 1990s, 150 mental health courts have been established across the country, confirming their popularity among law enforcement, judicial officials, and mental health professionals.[19] Mental health courts strive to increase public safety, reduce recidivism, and more properly accommodate the mentally ill by employing a problem-solving approach to court processing for mentally ill defendants.[20]

In 2007, a study conducted by the RAND Corporation was the first to analyze fiscal impacts of mental health courts.[21] Their study was focused on the Allegheny Mental Health Court Program in Pennsylvania. The study was over a two-year period and found that after the first year, admission into the mental health court program leads to an increase in mental health care treatment services, as well as a decrease in jail time.[22] The decrease in jail costs and the increase in mental health treatment services costs offset each other in the first year, according to the study, so there were no significant economic gains after year one. After year two, however, both the costs for the mental health treatment services and jail costs decreased, saving the state a significant amount of money and suggesting that mental health court programs may significantly help decrease the state's expenses on mental health care.[23]

It is also more economical for the state to spend money on mental health treatment programs than to simply put the mentally ill in jail. This is because the majority of the mentally ill are on Medicaid, and the state and the federal government split the costs for this program. As an example, the Genesis Community Mental Health Clinic in Laconia, one of New Hampshire's ten community mental health facilities, reports that Medicaid dollars represent 80 percent of the money coming in to the clinic.[24] With jails and prisons, however, the financial burden falls solely on the state and the taxpayers.

Finally, mental health court programs have been proven to help the health and lives of the mentally ill. New Hampshire's two mental health courts, in Keene and Nashua, are succeeding not only in saving the state money but also in providing the appropriate care for the mentally ill. Of the 128 people that had gone through the Keene mental health court by 2006, 70 percent completed the treatment program and were successfully diverted from jail-time.[25] Moreover, a study done by The American Journal of Psychiatry in 2007 showed that mental health court programs help reduce recidivism (the tendency of formerly incarcerated individuals to return to the corrections system again as a result of new offenses).[26] The reduction in recidivism is better for the mentally ill and saves money for the state since it results in fewer people who return to correctional facilities. Figures 1 and 2 illustrate the results of this study.

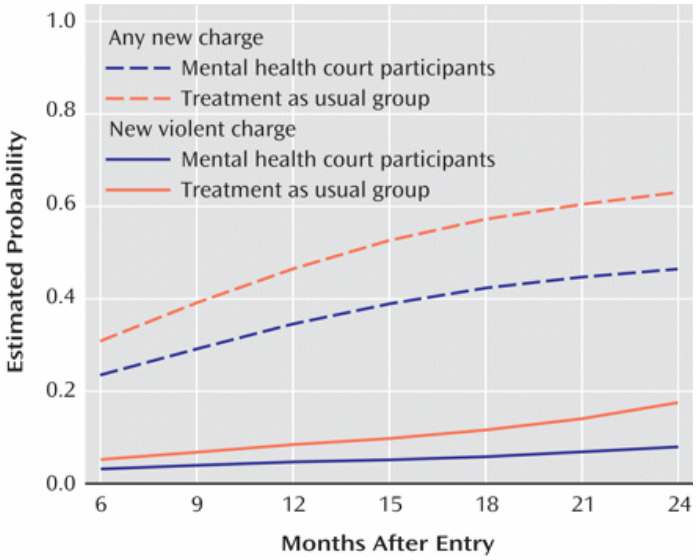

Figure 1: Estimated cumulative probability of a new charge for criminal defendants with mental disorders participating in mental health court or receiving treatment as usual, as a function of mental health court status and months after entry.[27]

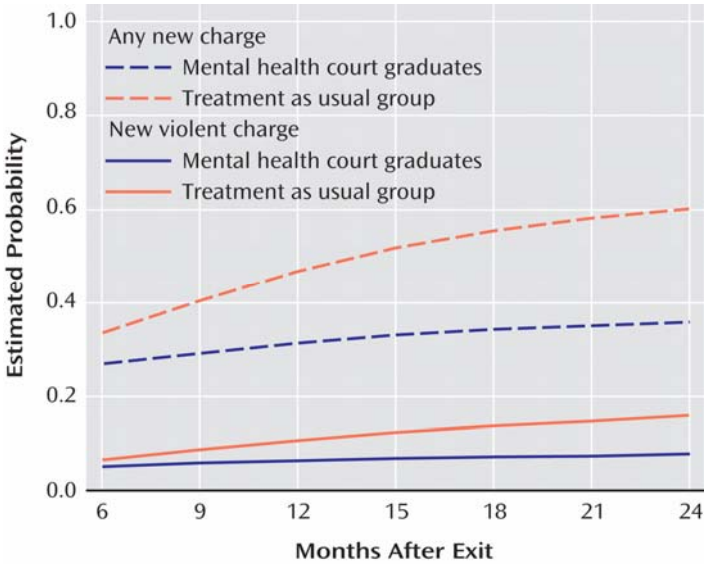

Figure 2: Estimated cumulative probability of a new charge for criminal defendants with mental disorders participating in mental health court or receiving treatment as usual, as a function of mental health court status and months after graduation.[28]

1.2.3 Shock Incarceration

Another potential cost-saving measure that has been very successful in New York State is the Shock Incarceration program, which serves as a sort of "boot camp prison for young adults."[29] Combining shorter incarceration periods with highly structured days and military-style discipline, the program in New York also has a strong educational component. As a result, the reading and math competencies of program graduates increase by one grade level on average.[30] The program has also led to dramatic savings in cost. Between the program's inception in 1987 and 2006, the New York Department of Correctional Services saved an estimated $1.18 billion in operating and capital costs.[31]

However, due to the intensive nature of shock incarceration, the program has a screening program that sets a variety of eligibility criteria relating to age, physical and mental health, and commitment to fulfilling the program.[32] Though the specific eligibility criteria are not listed within the National Institute of Justice report on Shock Incarceration, the report explicitly states that "participants are carefully examined for mental and physical problems that would prohibit them from taking part in the program."[33] Furthermore, the value of an intensive, boot-camp style prison experience for mentally ill prisoners is an issue that requires further research, as it is possible that this could have an adverse affect on their mental health treatment and care.

1.2.4 Telemedicine

Telemedicine is the process of a patient-doctor consultation occurring in a non-face-to-face manner. Given that some of the major costs of mental health care in correctional facilities involve transporting inmates and doctors between the correctional facility and the place where they will be examined, the process of having a videoconference between

a health care provider and a mentally ill inmate is a way that the state could potentially save money on mental health care without decreasing the quality of care for the mentally ill.[34] The impact of telemedicine has been more noticeable in rural areas than in urban areas, meaning the savings could be more significant in a state like New Hampshire.[35]

The major expenses of telemedicine involve the initial installation of the telemedicine equipment. Studies have shown that telemedicine equipment can range in cost from $50,000 to $75,000, depending on the level of technology.[36] In addition to the initial expense, hourly fees are incurred when the telemedicine equipment is used.[37] A report by the National Institute of Justice, however, found that this initial investment in equipment could be recovered in fifteen months.[38] In the future, the investment recovery could be even quicker if technology advances and the costs for telemedicine equipment decrease. The report found that monthly savings after the initial fifteen months could be upwards of $14,000.[39] The telemedicine program that exists in the Ohio Department of Rehabilitation and Correction saves between $200 and $1,000 for each use.[40]

Telemedicine will not eliminate all face-to-face consultations between mentally ill prisoners and specialists, but it can be used when deemed necessary by the experts and can save the state a great amount of money over time. In addition to the cost-reduction aspect of telemedicine, it may also lead to early intervention, which can help to control symptoms of mental illnesses before escalation requires more costly treatment. When used properly, telemedicine can save the state money without reducing the quality of care for the mentally ill.

1.2.5 Consolidating State and County Correctional Systems

There are 10 county jails in New Hampshire, each with varying numbers of mentally ill inmates (see Appendix A). Coos County, making up 20 percent of the area in New Hampshire, has a jail with only nine mentally ill inmates, while the smaller and more populous Hillsborough County has a jail with 87 mentally ill inmates.[41] When comparing county correctional budgets with the number of inmates in each jail, certain counties (such as Coos, Grafton and Carroll) spend disproportionately more on each inmate.[42] In addition, each county contracts out mental health care either fully or partially to various companies. Consolidating state and county prisons may increase efficiency and uniformity within the county prison system and could reduce overall corrections costs; specifically, mental health care could be standardized and more continuously administered.

Six states in the United States have consolidated their state and county correctional systems. Vermont began its consolidation process in 1967 when it converted four county jails into regional correction houses and closed several other county jails. Currently, Vermont has nine different correctional centers, each with different purposes.[43] While Vermont has cut costs by purchasing in bulk, costs continue to rise and correction centers continue to be overcrowded. With the consolidated system however, the state is more flexible and better able to handle overcrowding.

Currently, counties fully fund their jails with their revenue. In a consolidated system, the state would have to bear most of the costs with very little support from the counties. In addition, transporting inmates from their county to appropriate correctional centers may be costly.[44] This policy option may help lower some costs of the overall corrections system by improving efficiency but would not likely help lower the costs incurred due to recidivism and expensive medications.

1.2.6 Reduce the Costs of Psychotropic Medications

Vermont currently reduces the costs of its psychotropic medications by using formularies that are similar to those used by Medicaid. Formularies encourage the use of generic psychotropic medications instead of brand name medications by attaching lower co-payments to generic drugs and higher co-payments to more expensive brand name drugs.[45] Currently, the number one drug prescribed and used in the New Hampshire correctional facilities is Seroquel, an anti-psychotic medication.[46] Vermont cut down Seroquel's use from 110 prescriptions in 2006 to five prescriptions in 2007.[47] By replacing expensive medications such as these with cheaper generic medications, the state may be able to cut down its prescription costs.

2. QUALITY

Although quality and cost are interrelated, this report addresses quality as an independent issue. While maintaining an understanding of the costs is important, quality may ultimately determine the success of the program.

The example of recidivism helps demonstrate the importance of a high quality mental health system for prison inmates. As discussed briefly with regard to mental health courts, recidivism can impose substantial costs for the state and county if mental health problems are not adequately addressed during a prison and post-prison sentence.[48] Among local jail inmates, 32 percent who had a documented mental health problem were repeat offenders, while 22 percent of jail inmates without a mental health issue were violent recidivists.[49] In a 2006 special report produced by the Bureau of Justice Statistics, it was estimated that 47 percent of State prisoners with one or more mental illnesses had served three or more prior probation or incarceration sentences. This is compared to the 39 percent who also had prior sentences but no history of mental health issues.[50] Moreover, State prisoners with mental illnesses were more likely to have a current or past violent offense.[51] One study, which surveyed 3,430 individuals with mental illnesses, found that 44 percent had been arrested at some point in their lives.[52]

2.1 Quality-related policy options

2.1.1 Improve patients' needs assessment

Inmates received into the New Hampshire prison system undergo a screening for mental health concerns. This screening is crucial to the inmate. Overlooking a mental health problem can have negative ramifications ranging (depending the severity of the issue)

from inmate suicide to repeat and costly recidivism. Although there aren't currently any "validated instruments for mental health screening in adult populations,"[53] such screening should include several key elements:

- Face-to-face interaction between inmate and individual performing the screening
- Immediacy; the patient should be screened as close to arrival as possible, not longer than 14 days
- A tendency to over-diagnosis. Initial screenings should err on the side of caution: Mental health professionals can weed out inappropriately diagnosed inmates upon referral.

The elderly provide a good example of the importance of proper assessment and the related issue of specialized needs. Statistics have shown that New Hampshire's elderly within the prison system are growing at an alarming rate. The population of inmates over 61 has doubled over the past decade. It is important to acknowledge the population shift considering that the elderly have not only an increased likelihood of suffering from mental illnesses such as dementia but higher suicide rates than any other age group.[54]

Due to specialized needs, the cost implications for treating and managing elderly prisoners are substantially higher than other prison populations. The average annual cost for the general prison population in New Hampshire is $24,143.[55] However, in one study conducted in California, it is estimated that the annual cost for incarcerating a geriatric prisoner is approximately $70,000.[56] In addition, as mentioned above, older inmates require more psychotropic medications, which increases the amount that states spend on these drugs.

2.1.2 Focus on and improve corrections officer training

Growing concerns about inmate treatment and care within the corrections system point to the need for comprehensive mental illness education and training across the system. Corrections officer training is of particular importance, as inmates come into contact with corrections officers on a daily basis. Trained in punishment, corrections officers are often unaware of the most appropriate and effective ways to deal with mentally ill inmates.[57] The National Alliance on Mental Illness (NAMI) has identified training and education as fundamental to improving care and treatment for mentally ill prisoners. The following statement represents NAMI's belief that all judicial and legal personnel who interact with mentally ill prisoners should be appropriately trained to do so:

> NAMI believes that education about brain disorders at all levels of judicial and legal systems is crucial to the appropriate disposition of cases involving offenders with brain disorders. Judges, lawyers, police officers, correctional officers, parole and probation officers, law enforcement personnel, court officers, and emergency medical transport and service personnel should be required to complete at least 20 hours of training

> about these disorders. Consumers and family members should be a part of this educational process.[58]

Improved and increased training for corrections officers and other law enforcement and judicial officials will not only allow for more effective care for mentally ill inmates, but will allow for comprehensive care as well, reaching beyond the direct psychiatric care provider to all personnel with whom an inmate interacts.

2.1.3 Make greater use of outside resources

Outside resources can help supplement the services provided within the New Hampshire state prison system. These resources can help ease the transition both into and out of prison, provide counseling while the inmate is incarcerated, and potentially even help reach at risk populations to prevent incarceration.

One example of an opportunity to use outside resources involves an existing New Hampshire Prison contract with the Dartmouth Medical Services (DMS) Psychiatric Division. This promising program received attention from experts nationally and is cited as a model for others. However, it appears the program has not been used to its full potential. Therefore, this report recommends further exploration and greater use of the DMS services.

2.1.4 Apply the Assertive Community Treatment model

Mental health professionals recognize the complex needs of patients suffering from mental illness. These needs often require a multitude of professionals to handle a single person or a single person to manage a range of needs. In the prison system, a patient's care becomes additionally complicated – and potentially impaired – by the lack of cohesion between the various individuals attending to the inmate's needs.

The Assertive Community Treatment (ACT)[59] model helps address this area of concern by creating a network of professional support for the inmate. An evidence-based practice supported by nearly 25 years of research, the ACT model creates a team that serves patients through an individualized and pro-active approach. This team may address issues of substance abuse as well as integration into the community. For this reason, the team may be helpful in periods of transition or as a preventative measure. Although this model was not created explicitly for prison systems, the Council of State Governments recommended application of ACT to prison systems as a part of an extensive 2002 report.[60]

2.1.5 Create a "fast track" program to facilitate the re-application/application process for Medicaid

In the 1976 case *Estelle v. Gamble*, the Supreme Court found that the "cruel and unusual punishment clause" under the Eighth Amendment of the US Constitution guaranteed both

physical and mental health care for inmates.[61] This federal case, coupled with Medicaid's federal restrictions, placed the full burden of medical costs for inmates onto the state.

Under federal regulations for Medicaid, Federal matching funds (FFP) are not available to an individual who is an inmate of a public institution. Known as the "inmate exception" of the Social Security Act, this policy denies states from receiving federal reimbursements for medical care payments for both physical and mental health services. Inmates may qualify for Medicaid only if the individual is transferred from prison to a hospital for acute health services.[62]

There are two different policies states can implement in terms of Medicaid: suspension and termination. Most often, states employ a termination method when dealing with inmates, even for those released from jail within days. Termination, though not mandated by the Federal Government, is an act in which an individual with Medicaid coverage prior to incarceration has his or her medical benefits terminated upon entering prison. Recently released inmates are then forced to re-apply for Medicaid coverage. This process may take up to three months, during which treatment, medication, and health services are denied due to financial constraints.[63] With approximately 2.2 million people in the United States incarcerated on any given day and the vast majority being released during their lifetimes, treatment and services are vital for protecting the common welfare and for preventing a relapse for those with mental illnesses.[64]

For reducing overall costs and improving continuity of care, there are two possible options in regard to Medicaid. First, New Hampshire could *suspend* Medicaid enrollment for those inmates incarcerated for less than 30 days—allowing those with Medicaid to retain its benefits upon release. Second, if *termination* occurs as a response to being incarcerated for more than 30 days, New Hampshire could help to guide eligible inmates in the application/re-application process by working with Medicaid agencies and local prison staff. Effective and timely post-prison treatment can, in the long run, reduce the number of inmates by reducing the number of mentally ill repeat offenders. Studies have shown that those individuals with Medicaid coverage are more likely to utilize mental health services—and to do so more frequently—than those without Medicaid. Additionally, Medicaid and access to mental health treatment post-incarceration helps individuals to stay in the community longer than those without Medicaid benefits.[65]

Programs in Oregon and Washington provide examples of successful ways to deal with Medicaid-related issues:

- *Oregon*. Due to a federal waiver (Section 1115), the Medicaid agency in Lane County, Oregon, does not remove inmates from the Medicaid enrollment until the fifteenth day of their incarceration. As a result, inmates released within 14 days retain their Medicaid insurance and can access services immediately. Under Oregon's "fast track" system, the local Medicaid agency, in conjunction with the jail diversion staff, works to quicken the Medicaid application/re-application

process by working with individuals while still in custody. Most Medicaid applications are processed one to two days after release from prison.[66]

- *Washington*. Similar to Oregon, Washington suspends Medicaid enrollment for people in jails, but only after 30 days. The Department of Social and Health Services has hired an eligibility social worker to assist prisoners in the Seattle jail in accessing Medicaid insurance. Forty-five days before the projected prison release date, the inmate is connected with the social worker to map out service and treatment options. The Department of Social and Health Services has waived the face-to-face interview requirement for prisoners with addiction disorder issues or mental illnesses.[67]

4. CONCLUSION

Addressing the costs and quality of mental health care in prisons is an important task facing the State of New Hampshire. Costs continue to impose an increasing burden on the state, and many options are available for directly addressing this issue. For example, greater use of generic psychotropic medications would result in immediate savings. Over the longer term, the state may consider studying the possibility of consolidating the state and county correctional systems. The increasing costs may also be contained by several policies that should simultaneously improve the quality of care and/or reduce recidivism. These include: creating diversion programs, broadening the use of mental health courts, and/or implementing the use of telemedicine.

Apart from their costs, certain options are also available for increasing the quality of mental health care provided to inmates. These include: improving needs assessments, increasing the use of outside services, increasing and improving training on mental health disorders for corrections and criminal justice personnel, and/or creating a “fast track” program to facilitate the Medicaid application/re-application process.

Costs and quality of care are highly interrelated, and New Hampshire should carefully evaluate current practices within the state and the potential costs and benefits of the policies outlined in this report to maximize the effectiveness and efficiency of mental health care for inmates in state prisons and jails.

APPENDIX A. COUNTY INMATE POPULATIONS

Survey 1

December 14, 2005			
County	Total Inmate Population[1]	# Inmates Mental Illness[2]	% Mentally Ill to Total Population
Belknap	96	37	39%
Coos	34	9	26%
Grafton	133	32	24%
Hillsborough	502	87	17%
Merrimack	258	49	19%
Rockingham	296	80	27%
Strafford	258	105	41%
Sullivan	92	25	27%
Total	**1,669**	**424**	**25%**

1. Not reporting: Carroll and Cheshire Counties
2. Number of inmates with a diagnosis of mental illness is compiled from the number of inmates receiving psychotropic medications. It does not include inmates with medications that are non-compliant or inmates that were not yet evaluated.

Source: New Hampshire Association of Counties, *Initial Report: County Corrections Mental Health Initiative* (2006) p. 3.

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